STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155785	A. BUILDING 00 B. WING	11/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST RIVER HEALTH CAMPUS	714 S EICKHOFF RD EVANSVILLE, IN47712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Post Survey Revisit (PSR) to the Investigation of Complaint IN00096308 completed on October 6, 2011. Complaint IN00096308 Not Corrected. Unrelated deficiencies are cited. Survey dates: November 15 and 16, 2011 Facility number: 012448 Provider number: 155785 AIM number: N/A Survey team: Anne Marie Crays RN Census bed type: SNF: 33 Residential: 55 Total: 88 Census payor type: Medicare: 25 Other: 63 Total: 88 Sample: 10 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Quality review completed 11/17/11 Cathy Emswiller RN			
F0282 SS=E	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview, and record review, the facility failed to ensure medications were administered as prescribed by the physician, for 4 of 9 residents reviewed during medication passes, in a sample of 10. Residents D, B, A, and E Findings include:	F0282	F282Resident D's MAR and physician orders were reviewed with RN #1. Staff that administer medication to him have been inserviced on these orders as well as being checked off for proper administration of them.Completion Date 11-30-11Resident B's MAR has been reviewed with RN #1. Staff that administer medication to them and have been checked off	11/30/2011

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	1. On 11/15/11 at 12:10 P.M., RN # 1 indicated she was going to give Resident D his "upon rising" medications. RN # 1 indicated Resident D had been in the dining room at breakfast time, and she was not allowed to pass medications in the dining room. RN # 1 indicated she " had to compete with therapy" sometimes to give the resident his medications. RN # 1 proceeded to prepare medications with labels which indicated: Zinc 50 mg in am with breakfast, Glucotrol 5 mg [for blood sugar] in am before breakfast, and Glucophage 500 mg [for blood sugar] before breakfast. The Administrator was notified at that time that RN # 1 was preparing to administer the resident these medications, and indicated she would alert the Director of Nursing [DON]. Prior to the DON arriving, RN # 1 indicated it would be okay to give the Glucotrol and Glucophage, since "the order says before breakfast, and it is before lunch." The DON then arrived, and instructed RN # 1 to hold the medications, and inform the physician. The clinical record of Resident D was reviewed on 11/15/11 at 12:30 P.M. Diagnoses included, but were not limited to, Diabetes and Hypertension. Physician orders, dated November 2011, indicated: "Zinc 50 mg, Give 1 capsule by mouth in		for proper administration of these meds.Completion Date 11-30-11Resident A's MAR has been reviewed with RN #1. Staff that administer medications have been checked off on proper administration and the resident has been instructed on the correct order for the medication.Completion Date 11-30-11Resident E's MAR has been reviewed with RN #1 and other staff that administer her meds for check off of proper procedure and as ordered.Completion Date 11-30-11No other residents were affected by the deficient practice and through inservicing and competency completion will ensure that medications are administered as they are ordered and documented timely.Completion Date 11-30-11Licensed nursing staff inserviced on proper medication administration procedures and documentation of completion.Completion Date 11-30-11DHS/Designee will observe 1 nurse per day during med administration rotating shifts and hallways, and fill out observation report upon completion with identified concerns related to dosage, technique, timeframes, documentation, etc. Audits will be for 15days, then 1 per week for 30 days, then 1 monthly. Pharmacist will also randomly observe 1 nurse med pass per	

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	the morning with breakfast, Glucotrol 5 mg, Give 1 tablet by mouth in the morning before breakfast for DM [diabetes mellitus], Glucophage 500 mg tablet, Give 1 tablet by mouth every morning before breakfast." 2. On 11/15/11 at 9:55 A.M., during a medication pass, RN # 1 was observed to administer Resident B medications. On 11/15/11 at 10:45 A.M., the clinical record of Resident B was reviewed. Diagnoses included, but were not limited to, History of CVA [stroke] and Hypertension. A Physician's order, initially dated 2/10/11 and on the current November 2011 orders, indicated, "Norvasc 5 mg Give 1 tablet by mouth daily upon rising for HTN [hypertension]." RN # 1 had not been observed to administer the Norvasc with the earlier medication pass. The MAR was reviewed at that time, and none of the "after rising" medications were initialed as given. On 11/15/11 at 12:30 P.M., during interview with RN # 1, she did not provide an explanation regarding why the Norvasc had not been given. 3. On 11/15/11 at 10:40 A.M., during observation of a medication pass, RN # 1		month.Results of audits will be forwarded to QA committee monthly x 6 months and quarterly thereafter.	

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	was observed to administer medications to Resident A. One of the medications was Advair 100/50 inhaler, in which the label indicated "1 puff every 12 hours." RN # 1 gave the inhaler to the resident, and the resident proceeded to give himself 2 puffs of the inhaler. The clinical record of Resident A was reviewed on 11/15/11 at 11:35 A.M. A physician's order, initially dated 8/19/11 and on the current November 2011 orders, indicated, "Advair 100/50 Give 1 puff orally every 12 hours." The resident 's MAR was reviewed at that time, and indicated the resident was to receive the inhaler "Upon rising " and "HS" [bedtime]. 4. On 11/15/11 at 2:15 P.M., during observation of a medication pass, RN # 1 was observed to administer Resident E medications, which included Trental 400 mg [for stomach disorders]. When RN # 1 entered the resident 's room, the resident questioned, "Do I not get my Benefiber anymore? I didn't receive it this morning." RN # 1 then checked the MAR, and administered the resident Benefiber 1 packet. RN # 1 indicated at that time that she had looked at an entry on the MAR which indicated, "Benefiber, refuses, Duplicate order," and so didn't give it. An additional entry on the MAR indicated,			

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	"Benefiber 1 packet BID [with] meals, Breakfast, Supper." The clinical record of Resident E was reviewed on 11/15/11 at 2:45 P.M. Physician orders on the November 2011 order sheet included: "Trental 400 mg po TID [three times daily] upon rising, supper, HS," and "Benefiber BID [twice daily]." 5. On 11/15/11 at 3:00 P.M., the Administrator provided the current facility policy on "Specific Medication Administration Procedures," dated 2/1/10. The policy included: "Policy, To administer medications in a safe and effective manner...Check MAR [medication administration record] for order...Read medication label three (3) times...Compare label to MAR...After administration, return to care...and document administration in the MAR...If resident refuses medication, document refusal on MAR...." On 11/16/11 at 9:30 A.M., the Director of Nursing provided the current facility policy on "Medication Administration Times Procedural Guidelines," undated. The policy included: "...Unless a specific time is designated by the attending physician medications shall be administered at the following times: a.			

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	QD [every day] - after the resident awakes in the morning, b. BID - in the morning and at bedtime, c. TID - in the morning, around lunch time and at bedtime, d. QID [four times daily] - in the morning, around lunch time, around dinner time and at bedtime...The nurse shall note the time of the previous dose prior to administering the same medication to ensure it is not provided too close together...Medications that have been ordered at specific time [sic] shall be administered at the time designated by the attending physician." On 11/16/11 at 9:45 A.M., during interview with the Administrator, she indicated there was currently no policy regarding what "Upon rising" or "After rising" meant. This federal deficiency was cited on 10/6/11. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-35(g)(2)			

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F0332 SS=E	The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, interview, and record review, the facility failed to ensure a medication rate of no greater than 5%, in that a medication rate of 16% was calculated, which affected 4 of 9 residents reviewed during medication pass, in a sample of 10. there were 7 errors in 42 opportunities for error resulting in a 16.66 % error rate. Residents D, B, A, and E Findings include: 1. On 11/15/11 at 12:10 P.M., RN # 1 indicated she was going to give Resident D his "upon rising" medications. RN # 1 indicated Resident D had been in the dining room at breakfast time, and she was not allowed to pass medications in the dining room. RN # 1 indicated she "had to compete with therapy "sometimes to give the resident his medications. RN # 1 proceeded to prepare medications with labels which indicated: Zinc 50 mg in am with breakfast, Glucotrol 5 mg [for blood sugar] in am before breakfast, and Glucophage 500 mg [for blood sugar] before breakfast. The Administrator was notified at that time that RN # 1 was preparing to administer the resident these medications, and indicated she would	F0332	F332Resident D's MAR and physician orders were reviewed with RN #1. Staff that administer medication to him have been inserviced on these orders as well as being checked off for proper administration of them.Completion Date 11-30-11Resident B's MAR has been reviewed with RN #1. Staff that administer medication to them and have been checked off for proper administration of these meds.Completion Date 11-3-11Resident A's MAR has been reviewed with RN #1. Staff that administer medications have been checked off on proper administration and the resident has been instructed on the correct order for the medication.Completion Date 11-30-11Resident E's MAR has been reviewed with RN #1 and other staff that administer her meds for check off of proper procedure and as ordered.Completion Date 11-30-11No other residents were affected by the deficient practice and through inservicing and competency completion will ensure that medications are administered as they are ordered and documented timely.Completion Date 11-30-11Licensed nursing staff inserviced on proper medication administration procedures and	11/30/2011

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	alert the Director of Nursing [DON]. Prior to the DON arriving, RN # 1 indicated it would be okay to give the Glucotrol and Glucophage, since "the order says before breakfast, and it is before lunch." The DON then arrived, and instructed RN # 1 to hold the medications, and inform the physician. The clinical record of Resident D was reviewed on 11/15/11 at 12:30 P.M. Diagnoses included, but were not limited to Diabetes and Hypertension. Physician orders, dated November 2011, indicated: "Zinc 50 mg, Give 1 capsule by mouth in the morning with breakfast, Glucotrol 5 mg, Give 1 tablet by mouth in the morning before breakfast for DM [diabetes mellitus], Glucophage 500 mg tablet, Give 1 tablet by mouth every morning before breakfast." 2. On 11/15/11 at 9:55 A.M., during a medication pass, RN # 1 was observed to administer Resident B medications. RN # 1 reviewed the Medication Administration Record [MAR], and placed a dot in the box by each medication. RN # 1 was not observed to initial the boxes after the medication was administered. On 11/15/11 at 10:45 A.M., the clinical record of Resident B was reviewed. Diagnoses included, but were not limited		documentation of completion.Completion Date 11-30-11DHS/Designee will observe 1 nurse per day during med administration rotating shifts and hallways, and fill out observation report upon completion with identified concerns related to dosage, technique, timeframes, documentation, etc. Audits will be for 15 day, then 1 per week for 30 days, then 1 monthly. Pharmacist will also randomly observe 1 nurse med pass per month.Results of audits will be forwarded to QA committee monthly x 6 months and then quarterly thereafter.	

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	to, History of CVA [stroke] and Hypertension. A Physician's order, initially dated 2/10/11 and on the current November 2011 orders, indicated, "Norvasc 5 mg Give 1 tablet by mouth daily upon rising for HTN [hypertension]." RN # 1 had not been observed to administer the Norvasc with the earlier medication pass. The MAR was reviewed at that time, and none of the "after rising" medications were initialed as given. On 11/15/11 at 12:30 P.M., during interview with RN # 1, she did not provide an explanation regarding why the Norvasc had not been given. 3. On 11/15/11 at 10:40 A.M., during observation of a medication pass, RN # 1 was observed to administer medications to Resident A. One of the medications was Advair 100/50 inhaler, in which the label indicated "1 puff every 12 hours." RN # 1 gave the inhaler to the resident, and the resident proceeded to give himself 2 puffs of the inhaler. The clinical record of Resident A was reviewed on 11/15/11 at 11:35 A.M. A physician's order, initially dated 8/19/11 and on the current November 2011 orders, indicated, "Advair 100/50 Give 1 puff orally every 12 hours." The resident's			

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	MAR was reviewed at that time, and indicated the resident was to receive the inhaler "Upon rising" and "HS" [bedtime]. 4. On 11/15/11 at 2:15 P.M., during observation of a medication pass, RN # 1 was observed to administer Resident E medications, which included Trental 400 mg [for stomach disorders]. When RN # 1 entered the resident's room, the resident questioned, "Do I not get my Benefiber anymore? I didn't receive it this morning." RN # 1 then checked the MAR, and administered the resident Benefiber 1 packet. RN # 1 indicated at that time that she had looked at an entry on the MAR which indicated, "Benefiber, refuses, Duplicate order," and so didn't give it. An additional entry on the MAR indicated, "Benefiber 1 packet BID [with] meals, Breakfast, Supper." The clinical record of Resident E was reviewed on 11/15/11 at 2:45 P.M. Physician orders on the November 2011 order sheet included: "Trental 400 mg po TID [three times daily] upon rising, supper, HS," and "Benefiber BID [twice daily]." 5. On 11/15/11 at 3:00 P.M., the Administrator provided the current facility policy on "Specific Medication Administration Procedures," dated 2/1/10.			

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	The policy included: "Policy, To administer medications in a safe and effective manner...Check MAR [medication administration record] for order...Read medication label three (3) times...Compare label to MAR...After administration, return to care...and document administration in the MAR...If resident refuses medication, document refusal on MAR...." On 11/16/11 at 9:30 A.M., the Director of Nursing provided the current facility policy on "Medication Administration Times Procedural Guidelines," undated. The policy included: "...Unless a specific time is designated by the attending physician medications shall be administered at the following times: a. QD [every day] - after the resident awakes in the morning, b. BID - in the morning and at bedtime, c. TID - in the morning, around lunch time and at bedtime, d. QID [four times daily] - in the morning, around lunch time, around dinner time and at bedtime...The nurse shall note the time of the previous dose prior to administering the same medication to ensure it is not provided too close together...Medications that have been ordered at specific time [sic] shall be administered at the time designated by the attending physician." On 11/16/11 at 9:45 A.M., during			

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	interview with the Administrator, she indicated there was no current policy regarding what "Upon rising" or "After rising" meant. This federal tag relates to Complaint IN00096308. 3.1-25(b)(9)			

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F0441 SS=D	The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F0441	F441Res C suffered no ill effects from the findings on the 2567L and licensed staff have been inserviced on proper PICC flushing.Completion Date 11-30-11There were no other	11/30/2011

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	Based on observation, interview, and record review, the facility failed to ensure staff correctly flushed a PICC [peripherally inserted central catheter] line, which could lead to the potential for infection, for 1 of 1 residents reviewed with intravenous medications, in a sample of 10. Resident C Findings include: On 11/15/11 at 11:10 A.M., RN # 1 indicated she was going to administer an intravenous [IV] medication to Resident C. A PICC line was observed in Resident C 's right arm, which had 2 separate ports, or lumens. RN # 1 proceeded to flush each of the ports with 5 cc normal saline, using the same syringe. When interviewed at that time, RN # 1 indicated, "I use a 10cc syringe, and flush each port with half of the normal saline. " On 11/15/11 at 1:45 P.M., the Director of Nursing provided the current facility policy on "Flushing IV Access Devices," undated. The policy included: "...Peripheral IV [PIV]...2-3cc of N/S [normal saline] before and after infusion...Midline and PICC's: (flush each lumen of catheter even when not in use), Procedure the same as PIV's except use 10cc syringes and 3-5cc of N/S...."		residents affected by the alleged deficient practice and through alterations in processes and inservicing will ensure correct actions to prevent spread infection are followed.Completion Date 11-30-11Nursing staff will be inserviced on proper PICC flushing to prevent spreading of infection. Systemic changes will be that nursing staff will use separate syringes for each port flush. Return demonstration of skill will be documented.Completion Date 11-30-11DHS/Designee will monitor resident medicatio administration that includes PICC flushing techniques daily x 5 days, 3 x week for 2 weeks, then weekly with results of compliance being forwarded to QA committee monthly x 6 months and quarterly thereafter.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155785	A. BUILDING 00 B. WING	11/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	On 11/15/11 at 1:50 P.M., during interview with the Administrator, she indicated it would be standard nursing practice not to use the same syringe to flush both of the ports. 3.1-18(j)			